STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29C0001032	A. BUILDING _____ B. WING _____	04/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON ENDOSCOPY CENTER	707 N MINNESOTA CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS The following Statement of Deficiencies was generated as the result of a full Medicare survey conducted at your facility on 4/24/08. The full Medicare survey was directed by the Centers for Medicare and Medicaid Services as the result of Complaint # NV00017897. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The facility was not in compliance with the following Conditions for Coverage: CFR.416.42 Surgical Services The following deficiencies were identified.	Q 000		
Q 005	416.42 SURGICAL SERVICES Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ambulatory surgical center in accordance with approved policies and procedures of the center. This CONDITION is not met as evidenced by: Based on record review, observation and interviews from 4/24/08 to 4/25/08, the facility failed to perform surgical procedures in a safe manner regarding electrocautery, sterilization procedures, and storage of sterilized items. Findings include:	Q 005		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 005	Continued From page 1 Electrocautery: Procedure room's #1 and #2 were observed from 9:30 AM to 12:30 PM on 4/24/08. Each room contained an electrocautery unit. Opened patient return electrodes (out of their packages) were observed plugged into each electrocautery unit. An endoscopy technician assigned to procedure room #1 reported at 12:30 PM that she opened the patient return electrode in her assigned room at about 6:45 AM. That electrode had been out of its wrapper for approximately six hours. The registered nurse and endoscopy technician assigned to procedure room #2 reported at 9:30 AM that they did not open the patient return electrode in their assigned room and did not know when it was originally unwrapped. An endoscopy technician reported that staff would open the electrode wrappers and plug the electrodes in so that they were ready in case the physicians needed to use the electrocautery units. The manufacturer's package insert indicated the patient return electrode package should be opened just prior to applying the electrode to the skin. A manufacturer's representative stated on 4/25/08, at 8:30 AM that the electrode needed to be applied just prior to use to prevent the electrode gel from drying out and causing an electrocautery burn. Sterilization procedures: At 3:30PM on 4/24/08, the room storing processed endoscopes was entered. An endoscopy technician was observed placing small metal instruments in paper "peel packs" in preparation for steam sterilization. The "peel packs" were laying on the counter next to a small	Q 005		

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Q 005	Continued From page 2	Q 005		

sink filled with water and instruments. Water was observed on the counter surrounding the "peel packs" and underneath the "peel packs." Contact with water can compromise the integrity of the paper "peel packs" and jeopardize the sterilization process.

Storage of sterilized items:

The decontamination room was observed at 8:30 AM on 4/24/08. A metal rack with multiple shelves was noted. The shelves were used to store multiple irrigation bottles in a bucket, three irrigation caps with tubing and twenty sterilized biopsy forceps. An endoscopy technician was interviewed regarding the storage of sterile instruments in the room designated as the decontamination room. The technician stated the twenty sterile biopsy forceps were being stored on the shelf until the sterilization spore company could verify that they were sterile. On the shelf directly above the sterilized instrument packages were hanging three irrigation caps with their tubing attached. The technician reported that irrigation bottles, their caps and tubing were processed through the automatic endoscope re-processing units and after they were processed, the bottles were placed in a bucket to dry and the caps with their tubing were hung from the wire rack to drip-dry. Allowing the cap and tubing assemblies to drip-dry directly over sterile instrument packages compromises the sterility of the packages.

The room storing processed scopes was observed at 12:00 PM on 4/24/08. A blue canvas bag was noted hanging from a hook on the back of a door. The bag contained multiple esophageal dilators in the main section of the bag

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Q 005	Continued From page 3 and eight sterile "peel packs" of hemostats in a small zippered pouch on the outside of the bag. An endoscopy technician reported that after the esophageal dilators were used, they were disinfected in the automatic scope reprocessing units, their lumens were blown dry with compressed air and then they were placed in the bag for storage. There was no rubber barrier between the dilators and sterile pouches that would prevent any moisture from incompletely dried esophageal dilators from wicking through the canvas material and contaminating the sterile pouches in the adjacent pouch.	Q 005		
Q 016	416.44(c) EMERGENCY EQUIPMENT Emergency equipment available to the operating rooms must include at least the following: o Emergency call system. o Oxygen. o Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. o Cardiac defibrillator. o Cardiac monitoring equipment. o Tracheostomy set. o Laryngoscopes and endotracheal tubes. o Suction equipment. o Emergency medical equipment and supplies specified by the medical staff. This STANDARD is not met as evidenced by: Based on observation and interview on 4/24/08, it was determined that the facility did not have a tracheostomy set. Findings include: The facility crash cart was inspected. The crash	Q 016		

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Q 016	Continued From page 4 cart contained an Abelson Cricothyrotomy cannula and a MiniTrach II kit. Neither item is considered a tracheostomy set. The clinical director confirmed that the facility did not have a tracheostomy set.	Q 016		